

Facility Name & ID Number NORWEGIAN LUTHERAN BETHESDA ASSOCIATION# 0012229 Report Period Beginning: 01/01/00 Ending: 12/31/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds N/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>36</u>	Skilled (SNF)	<u>36</u>	<u>13,176</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>86</u>	Intermediate (ICF)	<u>86</u>	<u>31,476</u>	3
4		Intermediate/DD			4
5	<u>34</u>	Sheltered Care (SC)	<u>34</u>	<u>12,444</u>	5
6		ICF/DD 16 or Less			6
7	<u>156</u>	TOTALS	<u>156</u>	<u>57,096</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>410</u>	<u>1,210</u>	<u>1,292</u>	<u>2,912</u>	8
9	SNF/PED					9
10	ICF	<u>5,723</u>	<u>31,156</u>		<u>36,879</u>	10
11	ICF/DD					11
12	SC		<u>11,373</u>		<u>11,373</u>	12
13	DD 16 OR LESS					13
14	TOTALS	<u>6,133</u>	<u>43,739</u>	<u>1,292</u>	<u>51,164</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 89.61%

D. How many bed-hold days during this year were paid by Public Aid?

None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

N/A

F. Does the facility maintain a daily midnight census?

YesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☐NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☒NO ☐

I. On what date did you start providing long term care at this location?

Date started 1925

J. Was the facility purchased or leased after January 1, 1978?

YES ☐Date NO ☒

K. Was the facility certified for Medicare during the reporting year?

YES ☒NO ☐

If YES, enter number

of beds certified 8and days of care provided 1,292Medicare Intermediary Administar Federal

IV. ACCOUNTING BASIS

ACCRUAL ☒

MODIFIED

CASH* ☐CASH* ☐

Is your fiscal year identical to your tax year?

YES ☒NO ☐Tax Year: 12/31/00Fiscal Year: 12/31/00

* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

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Facility Name & ID Number NORWEGIAN LUTHERAN BETHESDA A# 0012229 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
1	Dietary	349,805	52,399	60,676	462,880		462,880		462,880			1
2	Food Purchase		299,828		299,828	(10,376)	289,452	(34,816)	254,636			2
3	Housekeeping	198,679	39,380		238,059		238,059		238,059			3
4	Laundry	44,993	4,862		49,855		49,855		49,855			4
5	Heat and Other Utilities			146,581	146,581		146,581		146,581			5
6	Maintenance	109,185		99,689	208,874		208,874	(1,819)	207,055			6
7	Other (specify):*											7
8	TOTAL General Services	702,662	396,469	306,946	1,406,077	(10,376)	1,395,701	(36,635)	1,359,066			8
9	B. Health Care and Programs											
9	Medical Director			10,800	10,800		10,800		10,800			9
10	Nursing and Medical Records	1,955,041	137,613	213,517	2,306,171		2,306,171		2,306,171			10
10a	Therapy			1,475	1,475		1,475		1,475			10a
11	Activities	126,596	10,881		137,477		137,477		137,477			11
12	Social Services	35,007	924	11,400	47,331		47,331		47,331			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,116,644	149,418	237,192	2,503,254		2,503,254		2,503,254			16
17	C. General Administration											
17	Administrative	118,010			118,010		118,010		118,010			17
18	Directors Fees											18
19	Professional Services			192,834	192,834		192,834	(98,291)	94,543			19
20	Dues, Fees, Subscriptions & Promotions			112,219	112,219		112,219	(50,060)	62,159			20
21	Clerical & General Office Expenses	229,308	14,762	72,131	316,201		316,201	(38,402)	277,799			21
22	Employee Benefits & Payroll Taxes			508,398	508,398	10,376	518,774		518,774			22
23	Inservice Training & Education											23
24	Travel and Seminar			8,130	8,130		8,130	(3,363)	4,767			24
25	Other Admin. Staff Transportation			1,331	1,331		1,331		1,331			25
26	Insurance-Prop.Liab.Malpractice			41,098	41,098		41,098	(7,016)	34,082			26
27	Other (specify):*											27
28	TOTAL General Administration	347,318	14,762	936,141	1,298,221	10,376	1,308,597	(197,132)	1,111,465			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,166,624	560,649	1,480,279	5,207,552		5,207,552	(233,767)	4,973,785			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

NORWEGIAN LUTHERAN BETHESDA ASSOCIATION

0012229

COST REPORT RECLASSIFICATIONS

01/01/00

12/31/00

SCHEDULE V
LINE #

22	EMPLOYEE BENEFITS	10,376	
2	FOOD		10,376

To reclass cost of employee meals from raw food to employee benefits

33	REAL ESTATE TAX		
19	PROFESSIONAL FEES		

To reclass cost of appealing real estate taxes

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			391,686	391,686		391,686	(81,794)	309,892			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			238,993	238,993		238,993	(238,993)				32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			1,474	1,474		1,474		1,474			35
36	Other (specify):*			35,937	35,937		35,937	(35,436)	501			36
37	TOTAL Ownership			668,090	668,090		668,090	(356,223)	311,867			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		35,802	104,324	140,126		140,126	(3,029)	137,097			39
40	Barber and Beauty Shops			16,727	16,727		16,727		16,727			40
41	Coffee and Gift Shops		1,202		1,202		1,202		1,202			41
42	Provider Participation Fee			66,978	66,978		66,978		66,978			42
43	Other (specify):*	25,201			25,201		25,201	(25,202)	(1)			43
44	TOTAL Special Cost Centers	25,201	37,004	188,029	250,234		250,234	(28,231)	222,003			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,191,825	597,653	2,336,398	6,125,876		6,125,876	(618,221)	5,507,655			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Facility Name & ID Number NORWEGIAN LUTHERAN BETHESDA ASSOCIATIO # 0012229

Report Period Beginning: 01/01/00

Ending: 12/31/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(17,759)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(52,927)	30		9
10	Interest and Other Investment Income	(238,993)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance	(7,016)	26		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(38,402)	21		24
25	Fund Raising, Advertising and Promotional	(11,523)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(12,269)	20		28
29	Other-Attach Schedule	(239,332)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (618,221)		\$	30

OHF USE ONLY

48		49		50		51		52	
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B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (618,221)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification.

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

STATE OF ILLINOIS
NORWEGIAN LUTHERAN BETHESDA ASSOCIATION

Page 5A

Report Period Beginning: 00122229
Ending: 01/01/00
12/31/00

NON-ALLOWABLE EXPENSES		Amount	Sch, V Line Reference
1	Deferred Maintenance	\$	6
2	Amortization of Bond Issuance Fees	(25,436)	36
3	Apartment Marketing Expenses	(4,064)	20
4	Bond Trust Fees	(6,914)	20
5	Public Relations	(861)	20
6	Newsletter	(14,429)	20
7	Endowment Fund Expenses	(83,153)	19
8	Non Care Related Depreciation	(28,870)	30
9	Dietary Supply Income	(17,057)	2
10	Marketing Consultant	(15,138)	19
11	Marketing Salary	(25,202)	43
12	Out of State Seminar	(3,363)	24
13	Depreciation Adjustment	3	30
14	Prior Medicare Supplies	(3,029)	39
15	Reclass Fixed Asset	(1,819)	6
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
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74			74
75			75
76			76
77			77
78			78
79			79
80			80
81			81
82			82
83			83
84			84
85			85
86			86
87			87
88			88
89			89
90	Total	(239,332)	90

Summary A

0012229

01/01/00

Ending:

12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

[illegible]

Summary B

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

[illegible]

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Schedule N/A						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES
☒ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3	4	5	6	7	8	
Schedule V		Line	Cost Per General Ledger	Amount	Cost to Related Organization	Percent of Ownership	Operating Cost of Related Organization	Difference: Adjustments for Related Organization Costs (7 minus 4)	
			Item		Name of Related Organization				
1	V			\$			\$	\$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$			\$	\$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES
 ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V						\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	0 \$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES
 ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V							\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$ 0	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number **NORWEGIAN LUTHERAN BETHESDA ASSOCIATION**# **0012229**Report Period Beginning: **01/01/00**Ending: **12/31/00****VII. RELATED PARTIES (continued)**

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger		4		5 Cost to Related Organization		6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount			Name of Related Organization		Percent of Ownership	Operating Cost of Related Organization		
15	V									\$	15
16	V										16
17	V										17
18	V										18
19	V										19
20	V										20
21	V										21
22	V										22
23	V										23
24	V										24
25	V										25
26	V										26
27	V										27
28	V										28
29	V										29
30	V										30
31	V										31
32	V										32
33	V										33
34	V										34
35	V										35
36	V										36
37	V										37
38	V										38
39	Total		\$						\$ 0	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$ 0	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$ 0	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number **NORWEGIAN LUTHERAN BETHESDA ASSOCIATION**# **0012229**Report Period Beginning: **01/01/00**Ending: **12/31/00****VII. RELATED PARTIES (continued)**

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	0 \$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$ 0	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$ 0	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number **NORWEGIAN LUTHERAN BETHESDA ASSOCIATION**# **0012229**Report Period Beginning: **01/01/00**Ending: **12/31/00****VII. RELATED PARTIES (continued)**

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger		4	5 Cost to Related Organization		6	7		8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V		Line	Item	Amount	Name of Related Organization		Percent of Ownership	Operating Cost of Related Organization				
15	V			\$				\$		\$		15
16	V											16
17	V											17
18	V											18
19	V											19
20	V											20
21	V											21
22	V											22
23	V											23
24	V											24
25	V											25
26	V											26
27	V											27
28	V											28
29	V											29
30	V											30
31	V											31
32	V											32
33	V											33
34	V											34
35	V											35
36	V											36
37	V											37
38	V											38
39	Total			\$				\$	0	\$ *		39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number NORWEGIAN LUTHERAN BETHESDA # 0012229 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Schedule N/A								\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees)
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME,
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number NORWEGIAN LUTHERAN BETHESDA ASSOCIATIC # 0012229 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number (_____) _____

Fax Number (_____) _____

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1									1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number NORWEGIAN LUTHERAN BETHESDA ASSOCIATIC # 0012229 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number NORWEGIAN LUTHERAN BETHESDA ASSOCIATIC # 0012229 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number NORWEGIAN LUTHERAN BETHESDA ASSOCIATIC # 0012229 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number NORWEGIAN LUTHERAN BETHESDA ASSOCIATIC # 0012229 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number NORWEGIAN LUTHERAN BETHESDA ASSOCIATIC # 0012229 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number NORWEGIAN LUTHERAN BETHESDA ASSOCIATIC # 0012229 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number NORWEGIAN LUTHERAN BETHESDA ASSOCIATIC # 0012229 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number NORWEGIAN LUTHERAN BETHESDA ASSOCIATIC # 0012229 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number NORWEGIAN LUTHERAN BETHESDA ASSOCIATIC # 0012229 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number **NORWEGIAN LUTHERAN BETHESDA A** # **0012229** Report Period Beginning: **01/01/00** Ending: **12/31/00**

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1							\$		\$			\$	1
2													2
3													3
4													4
5													5
	Working Capital												
6	IHFA Bond Issue		X	Construction and Renovation		11/99	4,015,000	3,880,000	Var	Var	238,993		6
7													7
8													8
9	TOTAL Facility Related						\$ 4,015,000	\$ 3,880,000			\$ 238,993		9
	B. Non-Facility Related*												
10	Supplemental Schedule												10
11													11
12													12
13									Interest Income		(238,993)		13
14	TOTAL Non-Facility Related						\$	\$			(238,993)		14
15	TOTALS (line 9+line14)						\$ 4,015,000	\$ 3,880,000					15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.

(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.

(See instructions.)

Facility Name & ID Number NORWEGIAN LUTHERAN BETHESDA ASSC# 0012229

Report Period Beginning:

01/01/00

Ending:

12/31/00**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE****A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)**

1		2		3	4	5	6	7	8	9	10
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO				Original	Balance			
1							\$	\$			\$
2											
3											
4											
5											
6											
7											
8											
9											
10											
11											
12											
13											
14											
15											
16											
17											
18											
19											
20											
21							\$	\$			\$

Facility Name & ID Number **NORWEGIAN LUTHERAN BETHESDA ASSOCIATION**# **0012229**

Report Period Beginning:

01/01/00

Ending:

12/31/00**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

1. Real Estate Tax accrual used on 1999 report.	\$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	\$	2
3. Under or (over) accrual (line 2 minus line 1).	\$	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	\$	5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6	\$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	1995	8
	1996	9
	1997	10
	1998	11
	1999	12

Schedule N/A Non-Profit Organization

FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 1999	13
14	PLUS APPEAL COST FROM LINE 5	14
15	LESS REFUND FROM LINE 6	15
16	AMOUNT TO USE FOR RATE CALCULATION\$	16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number NORWEGIAN LUTHERAN BETHESDA ASSOCIATION

0012229

Report Period Beginning:

01/01/00

Ending:

12/31/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 67,403 B. General Construction Type: Exterior Brick Frame _____ Number of Stories 4

C. Does the Operating Entity? ☒ (a) Own the Facility ☐ (b) Rent from a Related Organization. ☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? ☒ (a) Own the Equipment ☐ (b) Rent equipment from a Related Organization. ☐ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

Apartment Building - 19 Units

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? ☐ YES ☒ NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	<u>Facility</u>		<u>1919</u>	<u>\$ 11,397</u>	1
2					2
3	TOTALS			\$ 11,397	3

Facility Name & ID Number NORWEGIAN LUTHERAN BETHESDA ASSOCIATION# 0012229

Report Period Beginning:

01/01/00

Ending:

12/31/00

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	43		1925	1925	\$ 73,089	\$	65	\$		\$ 73,089	4
5	75		1955	1955	657,001	10,108	65	10,108		457,380	5
6	40		1991	1991	2,108,648	42,470	30	70,783	28,313	648,843	6
7	-2		1997	1997	266,174	13,745	20	13,308	(437)	23,938	7
8											8
9	Improvement Type**										
9	Various		1956	1956	4,130	64	65	64		2,831	9
10	Various		1957	1957	4,771		40	(75)	(75)	4,771	10
11	Various		1958	1958	14,177	141	62	141		11,436	11
12	Various		1960	1960	27,510		30			27,510	12
13	Various		1966	1966	15,090		20			15,090	13
14	Various		1970	1970	434		20			434	14
15	Various		1974	1974	8,296		20			8,296	15
16	Various		1975	1975	5,599		20			5,599	16
17	Various		1976	1976	88,074		10			88,074	17
18	Various		1978	1978	91,490		10			91,490	18
19	Various		1979	1979	23,925		10			23,925	19
20	Various		1981	1981	4,090		10			4,090	20
21	Various		1982	1982	72,879		Var			72,879	21
22	Various		1983	1983	8,936		Var	(48)	(48)	8,936	22
23	Various		1984	1984	22,181		Var	738	738	19,424	23
24	Various		1985	1985	8,596		Var	345	345	7,350	24
25	Various		1986	1986	6,583		10			6,583	25
26											26
27											27
28											28
29											29
30											30
31											31
32	PAGE 12D TOTALS				1,080,721	6,135		5,353	(782)	5,353	32
33	PAGE 12C TOTALS				156,790	11,948		5,216	(6,732)	6,050	33
34	PAGE 12B TOTALS				253,898	28,474		11,112	(17,362)	21,194	34
35	PAGE 12A TOTALS				3,963,522	169,509		132,221	(37,288)	1,430,520	35
36	TOTAL (lines 4 thru 35)				\$ 8,966,604	\$ 282,594		\$ 249,266	\$ (33,328)	\$ 3,065,085	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number NORWEGIAN LUTHERAN BETHESDA ASSOCIATION# 0012229

Report Period Beginning:

01/01/00

Ending:

12/31/00

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various		1986		1,932,973	64,751	35	55,228	(9,523)	800,806	9
10	Various		1987		6,537	218	35	187	(31)	2,524	10
11	Various		1988		50,000	2,499	25	2,000	(499)	26,750	11
12	Various		1984		1,520		15	(3)	(3)	1,520	12
13	Various		1990		10,600		20	530	530	5,565	13
14	Various		1990		1,442,642	55,500	Var	49,172	(6,328)	452,584	14
15	Various		1992		52,486	8,933	30	1,750	(7,183)	21,629	15
16	Various		1993		59,972	6,787	20	2,999	(3,788)	26,086	16
17	Various		1994		19,138	219	20	957	738	6,383	17
18	Various		1995		80,569	7,963	20	4,029	(3,934)	21,484	18
19	Auditorium Bathrooms		1996		53,722	1,791	20	2,686	895	13,430	19
20	Roof - West Building		1996		43,205	4,320	20	2,160	(2,160)	10,800	20
21	Staff Lounge Air Conditioning		1996		9,954	664	20	498	(166)	2,490	21
22	Kitchen Air Conditioning		1996		52,238	3,483	20	2,612	(871)	13,060	22
23	Treen Bench		1996		789		20	40	40	200	23
24	Cubicle Curtains		1997		4,421	886	20	221	(665)	866	24
25	Blinds		1997		907	180	20	45	(135)	177	25
26	Laundry - A/C		1997		5,585	559	20	279	(280)	1,046	26
27	Bathroom Renovation		1997		5,445	544	20	272	(272)	1,066	27
28	Bathroom Renovation		1997		14,551	1,455	20	728	(727)	2,790	28
29	Bathroom Renovation		1997		5,109	511	20	255	(256)	957	29
30	Bathroom Renovation		1997		17,622	1,762	20	881	(881)	3,304	30
31	Bathroom Renovation		1997		5,358	536	20	268	(268)	983	31
32	Auditorium Door Widening		1997		9,890	494	20	495	1	1,691	32
33	Activity Room Renovation		1997		49,551	2,478	20	2,478		7,847	33
34	Telephone Equipment		1997		1,013	203	20	51	(152)	157	34
35	Telephone Equipment		1997		27,725	2,773	20	1,403	(1,370)	4,325	35
36	TOTAL (lines 4 thru 35)				\$ 3,963,522	\$ 169,509		\$ 132,221	\$ (37,288)	\$ 1,430,520	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number NORWEGIAN LUTHERAN BETHESDA ASSOCIATION# 0012229

Report Period Beginning:

01/01/00

Ending:

12/31/00

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9		Kitchen Fire Door		1998	3,402	340	20	170	(170)	383	9
10		3W Flooring		1998	22,555	2,255	20	1,128	(1,127)	2,538	10
11		Ceiling Tile		1998	5,013	501	20	251	(250)	565	11
12		2N Flooring		1998	21,140	2,114	20	1,057	(1,057)	2,202	12
13		Elevator Doors		1998	4,350	625	20	218	(407)	654	13
14		Boiler Repairs		1998	2,898	290	20	145	(145)	362	14
15		Pump Repairs		1998	1,735	174	20	87	(87)	188	15
16		Carpeting		1998	1,200	400	20	60	(340)	150	16
17		Water Heater		1998	1,499	300	20	75	(225)	156	17
18		Outside Lighting		1998	1,176	118	20	59	(59)	143	18
19		Doors and Frames		1998	2,775	277	20	139	(138)	290	19
20		Ventilation Design Drawings, Door Widening, HVAC		1998	54,461	2,723	20	1,135	(1,588)	3,405	20
21		3rd Floor Renovabion		1997	5,492	139	20	275	136	825	21
22		Automatic Doors		1999	3,591	359	20	180	(179)	360	22
23		2W, 3W Decorating		1999	27,725	2,773	20	1,386	(1,387)	2,657	23
24		Vinyl Flooring		1999	4,700	940	20	235	(705)	411	24
25		Carpeting		1999	1,075	215	20	54	(161)	94	25
26		2W, 3W Bathroom Tile Repair		1999	6,150	615	20	308	(307)	387	26
27		Stair Treads		1999	470	157	20	24	(133)	38	27
28		Carpeting		1999	2,100	420	20	105	(315)	166	28
29		Roof		1999	19,300	1,930	20	965	(965)	1,447	29
30		Roof		1999	2,790	279	20	140	(139)	198	30
31		Wall Coverings		1999	890	297	20	45	(252)	60	31
32		Carpeting		1999	1,975	395	20	99	(296)	124	32
33		Floors - 2N, 2C		1999	40,299	8,060	20	2,015	(6,045)	2,519	33
34		Window Repair		1999	12,494	1,249	20	625	(624)	729	34
35		Sink		1999	2,643	529	20	132	(397)	143	35
36		TOTAL (lines 4 thru 35)			\$ 253,898	\$ 28,474		\$ 11,112	\$ (17,362)	\$ 21,194	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number NORWEGIAN LUTHERAN BETHESDA ASSOCIATION# 0012229

Report Period Beginning:

01/01/00

Ending:

12/31/00

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9			
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
4					\$	\$		\$	\$	\$	4	
5											5	
6											6	
7											7	
8											8	
	Improvement Type**											
9	Shower Panels		1999		5,172	1,034	20	259	(775)	268	9	
10	Carpeting		1999		2,380	476	20	119	(357)	218	10	
11	Drinking Fountain		1999		523	174	20	26	(148)	41	11	
12	Plumbing Work		1999		1,650	550	20	83	(467)	90	12	
13	Staff Dining Room		1999		1,891	378	20	95	(283)	174	13	
14	Tuckpointing/Caulking		1999		7,925	763	20	396	(367)	491	14	
15	Resident Telephone System		1999		31,402	3,140	20	1,570	(1,570)	2,093	15	
16	Telephone Port		1999		1,733	347	20	87	(260)	94	16	
17	Concrete		2000		7,391	739	20	370	(369)	370	17	
18	Kitchen Insulation		2000		3,947	592	20	164	(428)	164	18	
19	Carpeting		2000		2,200	330	20	92	(238)	92	19	
20	Wall Coverings		2000		5,450	1,212	20	182	(1,030)	182	20	
21	Door Widening		2000		2,575	129	20	75	(54)	75	21	
22	Carpeting		2000		4,358	436	20	127	(309)	127	22	
23	Wall Coverings		2000		3,296	330	20	96	(234)	96	23	
24	Window Repair		2000		1,427	71	20	42	(29)	42	24	
25	Chain Link Fence		2000		1,572	120	20	33	(87)	33	25	
26	Beauty Shop Relocation		2000		7,200	65	20	90	25	90	26	
27	Call System - Auditorium Washroom		2000		5,800	145	20	72	(73)	72	27	
28	Roofing		2000		35,527	296	20	296		296	28	
29	Outer Doors		2000		2,026	17	20	17		17	29	
30	Driveway Seal Coat		2000		431	36	20	9	(27)	9	30	
31	Handicap Switch		2000		784	52	20	16	(36)	16	31	
32	Elevator Work		2000		900	23	20	8	(15)	8	32	
33	Carpeting		2000		1,430	191	20	24	(167)	24	33	
34	Bathroom Repairs		2000		660	88	20	11	(77)	11	34	
35	JN Door Widening		2000		17,140	214	20	857	643	857	35	
36	TOTAL (lines 4 thru 35)				\$ 156,790	\$ 11,948		\$ 5,216	\$ (6,732)	\$ 6,050	36	

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number NORWEGIAN LUTHERAN BETHESDA ASSOCIATION# 0012229

Report Period Beginning:

01/01/00

Ending:

12/31/00

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Lobby Renovations			2000	550,116	2,290	20	2,292	2	2,292	9
10	Boiler Replacement			2000	459,935	1,278	20	1,916	638	1,916	10
11	Grease Trap Replacement			2000	14,440	361	20	241	(120)	241	11
12	Carpeting			2000	1,387	46	20	12	(34)	12	12
13	Wallpaper			2000	1,660	83	20	28	(55)	28	13
14	Additional Cabling			2000	1,214	405	20	5	(400)	5	14
15	Code Alert System			2000	50,150	1,672	20	836	(836)	836	15
16	Cooler Repairs			2000	1,819		20	23	23	23	16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				\$ 1,080,721	\$ 6,135		\$ 5,353	\$ (782)	\$ 5,353	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1		2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
4					\$	\$		\$	\$	\$	4	
5											5	
6											6	
7											7	
8											8	
	Improvement Type**											
9											9	
10											10	
11											11	
12											12	
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14											14	
15											15	
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27											27	
28											28	
29											29	
30											30	
31											31	
32											32	
33											33	
34											34	
35											35	
36	TOTAL (lines 4 thru 35)				\$	\$		\$	\$	\$	36	

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	2	3	4	5	6	7	8	9			
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
4					\$	\$		\$		\$	4	
5											5	
6											6	
7											7	
8											8	
	Improvement Type**											
9											9	
10											10	
11											11	
12											12	
13											13	
14											14	
15											15	
16											16	
17											17	
18											18	
19											19	
20											20	
21											21	
22											22	
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26											26	
27											27	
28											28	
29											29	
30											30	
31											31	
32											32	
33											33	
34											34	
35											35	
36	TOTAL (lines 4 thru 35)				\$	\$		\$	\$	\$	36	

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	2	3	4	5	6	7	8	9			
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
4					\$	\$		\$	\$	\$	4	
5											5	
6											6	
7											7	
8											8	
	Improvement Type**											
9											9	
10											10	
11											11	
12											12	
13											13	
14											14	
15											15	
16											16	
17											17	
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26											26	
27											27	
28											28	
29											29	
30											30	
31											31	
32											32	
33											33	
34											34	
35											35	
36	TOTAL (lines 4 thru 35)				\$	\$		\$	\$	\$	36	

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1		2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
4					\$	\$		\$	\$	\$	4	
5											5	
6											6	
7											7	
8											8	
	Improvement Type**											
9											9	
10											10	
11											11	
12											12	
13											13	
14											14	
15											15	
16											16	
17											17	
18											18	
19											19	
20											20	
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22											22	
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24											24	
25											25	
26											26	
27											27	
28											28	
29											29	
30											30	
31											31	
32											32	
33											33	
34											34	
35											35	
36	TOTAL (lines 4 thru 35)				\$	\$		\$	\$	\$	36	

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number NORWEGIAN LUTHERAN BETHESDA ASSOCIATION# 0012229

Report Period Beginning:

01/01/00

Ending:

12/31/00

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9			
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
4					\$	\$		\$	\$	\$	4	
5											5	
6											6	
7											7	
8											8	
9	Improvement Type**											
10											10	
11											11	
12											12	
13											13	
14											14	
15											15	
16											16	
17											17	
18											18	
19											19	
20											20	
21											21	
22											22	
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26											26	
27											27	
28											28	
29											29	
30											30	
31											31	
32											32	
33											33	
34											34	
35											35	
36	TOTAL (lines 4 thru 35)				\$	\$		\$	\$	\$	36	

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	2	3	4	5	6	7	8	9			
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
4					\$	\$		\$		\$	4	
5											5	
6											6	
7											7	
8											8	
	Improvement Type**											
9											9	
10											10	
11											11	
12											12	
13											13	
14											14	
15											15	
16											16	
17											17	
18											18	
19											19	
20											20	
21											21	
22											22	
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25											25	
26											26	
27											27	
28											28	
29											29	
30											30	
31											31	
32											32	
33											33	
34											34	
35											35	
36	TOTAL (lines 4 thru 35)				\$	\$		\$	\$	\$	36	

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	2	3	4	5	6	7	8	9			
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
4					\$	\$		\$	\$	\$	4	
5											5	
6											6	
7											7	
8											8	
9	Improvement Type**											
10												9
11												10
12												11
13												12
14												13
15												14
16												15
17												16
18												17
19												18
20												19
21												20
22												21
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27												26
28												27
29												28
30												29
31												30
32												31
33												32
34												33
35												34
36	TOTAL (lines 4 thru 35)				\$	\$		\$	\$	\$	35	
											36	

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	2	3	4	5	6	7	8	9	
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4					\$	\$		\$	\$	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
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24										24
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27										27
28										28
29										29
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32										32
33										33
34										34
35										35
36	TOTAL (lines 4 thru 35)				\$	\$		\$	\$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number **NORWEGIAN LUTHERAN BETHESDA ASSO# 0012229**

Report Period Beginning:

01/01/00

Ending:

12/31/00

XI. OWNERSHIP COSTS (continued)**C. Equipment Depreciation-Excluding Transportation. (See instructions.)**

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	\$ 852,461	\$ 67,051	\$ 51,793	\$ (15,258)		\$ 597,295	37
38	Current Year Purchases	88,930	8,761	4,420	(4,341)		4,420	38
39	Fully Depreciated Assets	88,581					88,581	39
40								40
41	TOTALS	\$ 1,029,972	\$ 75,812	\$ 56,213	\$ (19,599)		\$ 690,296	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	General	Shuttle Van	1994	\$ 34,300	\$ 4,413	\$ 4,413		5	\$ 34,300	42
43	General	Ford Windstar	1999	22,065	4,413	4,413		5	7,356	43
44										44
45										45
46	TOTALS			\$ 56,365	\$ 4,413	\$ 4,413			\$ 41,656	46

E. Summary of Care-Related Assets

	1	2	
	Reference	Amount	
47	Total Historical Cost (line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	\$ 10,064,338	47
48	Current Book Depreciation (line 36,col.5 + line 41,col.2 + line 46,col.5)	\$ 362,819	48
49	Straight Line Depreciation (line 36,col.7 + line 41,col.3 + line 46,col.6)	\$ 309,892	49
50	Adjustments (line 36,col.8 + line 41,col.4 + line 46,col.7)	\$ (52,927)	50
51	Accumulated Depreciation (line 36,col.9 + line 41,col.6 + line 46,col.9)	\$ 3,797,037	51

**

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52	East Building Renovation	\$ 1,478,812	\$ 28,870	\$ 440,086	52
53					53
54					54
55					55
56					56
57	TOTALS	\$ 1,478,812	\$ 28,870	\$ 440,086	57

G. Construction-in-Progress

	Description	Cost	
58			58
59			59
60			60
61			61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

NORWEGIAN LUTHERAN BETHESDA ASSOCIATION
0012229
RELATED COMPANY MOVABLE EQUIPMENT SCHEDULE
12/31/00

COMPANY NAME	COST	CURRENT BOOK (FED) DEPRECIATION	STRAIGHT LINE DEPRECIATION	ADJUSTMENTS	ACCUMULATED S/L DEPRECIATION
LINE 28: PRIOR YEARS					
	852,461	67,051	51,793	(15,258)	597,295
TOTALS	852,461	67,051	51,793	(15,258)	597,295

LINE 29: CURRENT YEAR

	88,930	8,761	4,420	(4,341)	4,420
TOTALS	88,930	8,761	4,420	(4,341)	4,420

LINE 30: FULLY DEPRECIATED

	88,581				88,581
TOTALS	88,581				88,581

TOTALS (Should Tie to Totals on Page 13)

	1,029,972	75,812	56,213	(19,599)	690,296
TOTALS	1,029,972	75,812	56,213	(19,599)	690,296

Facility Name & ID Number NORWEGIAN LUTHERAN BETHESDA ASSOCIATION# 0012229 Report Period Beginning: 01/01/00 Ending: 12/31/00

XII. RENTAL COSTS**A. Building and Fixed Equipment (See instructions.)**1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

**

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized
by the length of the lease _____.9. Option to Buy: ☐ YES ☐ NO Terms: _____ ***B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)**

15. Is Movable equipment rental included in building rental?

☐ YES ☒ NO16. Rental Amount for movable equipment: \$ 1,474

Description: _____

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$ 0	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. _____/2001 \$ _____

13. _____/2002 \$ _____

14. _____/2003 \$ _____

* If there is an option to buy the building,
please provide complete details on attached
schedule.** This amount plus any amortization of lease
expense must agree with page 4, line 34.

Facility Name & ID Number **NORWEGIAN LUTHERAN BETHESDA ASSOCIATION** # **0012229** Report Period Beginning: **01/01/00** Ending: **12/31/00**
XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.	2. CLASSROOM PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> COMMUNITY COLLEGE <input type="checkbox"/> HOURS PER AIDE _____	3. CLINICAL PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> HOURS PER AIDE _____
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
 (c) For in-house training programs only. Do not include fringe benefits.
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service	Cost	Units	Cost					
					1	Licensed Occupational Therapist	39-3	hrs	\$		
2	Licensed Speech and Language Development Therapist	39-3	hrs				2,027			2,027	2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist	39-3	hrs				62,384			62,384	4
5	Physician Care		visits								5
6	Dental Care		visits								6
7	Work Related Program		hrs								7
8	Habilitation		hrs								8
9	Pharmacy	39-2	# of prescrpts					25,905		25,905	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10
11	Academic Education		hrs								11
12	Exceptional Care Program										12
13	**SEE SUPPLEMENTAL Other (specify): SCHEDULE**							9,897		9,897	13
14	TOTAL			\$		\$	104,324	\$ 35,802		\$ 140,126	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SUPPLEMENTAL SCHEDULE OF MEDICAL SUPPLIES

<u>Special Services - Supplies (Column 6 - Other)</u>	<u>Amount</u>
1 Medical Supplies	9,027
2 X-Ray and Lab	870
3	
4	
5	
6	
7	
8	
9	
10	
	<u>9,897</u>
<u>Outside Therapies (Column 5 - Other)</u>	<u>Amount</u>
1 Respiratory Therapy	
2	
3	
4	
5	
6	
7	
8	
9	
10	
	<u></u>

Facility Name & ID Number **NORWEGIAN LUTHERAN BETHESDA ASSOCIATION # 0012229** Report Period Beginning: **01/01/00** Ending: **12/31/00**
XV. BALANCE SHEET - Unrestricted Operating Fund. As of **12/31/00** (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 119,239	\$	1
2	Cash-Patient Deposits	1,865		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	362,866		3
4	Supply Inventory (priced at)	17,935		4
5	Short-Term Investments			5
6	Prepaid Insurance	19,317		6
7	Other Prepaid Expenses	17,531		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See supplemental schedule	1,259		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 540,012	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	11,397		13
14	Buildings, at Historical Cost	9,589,631		14
15	Leasehold Improvements, at Historical Cos			15
16	Equipment, at Historical Cost	1,596,787		16
17	Accumulated Depreciation (book methods)	(4,072,598)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	11,073,686		21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See supplemental schedule	229,059		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 18,427,962	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 18,967,974	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 136,915	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	393,410		28
29	Short-Term Notes Payable	135,000		29
30	Accrued Salaries Payable	153,321		30
31	Accrued Taxes Payable (excluding real estate taxes)	7,562		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	77,930		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See supplemental schedule	19,000		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 923,138	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	3,745,000		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See supplemental schedule	569,381		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 4,314,381	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 5,237,519	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ 13,730,455	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 18,967,974	\$	48

*(See instructions.)

STATE OF ILLINOIS

Page 17 SUPP-1

Facility Name & ID Number NORWEGIAN LUTHERAN BETHESDA ASSOCIATIC# 0012229

Report Period Beginning: 01/01/00

Ending:

12/31/00

SUPPLEMENTAL SCHEDULE OF OTHER ASSETS & LIABILITIES

As of 12/31/00

OTHER CURRENT ASSETS:

Amount

Amount

Accrued Interest Receivable

1,259

OTHER CURRENT LIABILITIES:

Amount

Amount

Accrued Group Medical Claims

19,000

1,259

19,000

OTHER NON CURRENT ASSETS:

Cemetery Lots

2,195

Bond Issuance Fees - Net

196,178

Unamortized Bond Discount - Net

30,686

229,059

OTHER NON CURRENT LIABILITIES:

Deferred Revenue - Ref Ten Dep

419,407

Deferred Revenue - Nonref Ten Dep

149,974

569,381

XVI. STATEMENT OF CHANGES IN EQUITY

		1	
		Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 14,284,547	1
2	Restatements (describe):		2
3	Schedule attached	(1)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 14,284,546	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(679,507)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	125,416	11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (554,091)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 13,730,455	24

* This must agree with page 17, line 47.

Facility Name & ID Number	NORWEGIAN LUTHERAN BETHESL#	0012229	Report Period Beginning:	01/01/00	Ending:	12/31/00
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Balance per General Ledger	14,284,546
----------------------------	------------

Adjustments:

-
-
-

1

Total adjustments

1

Balance - Beginning of Year

14,284,547

Equity(Deficit) from Page 17 Col 1

13,730,455

Related Party

Equity(Deficit)

0

Income

0

-

Combined Equity - End of Year

13,730,455

Facility Name & ID Number NORWEGIAN LUTHERAN BETHESDA ASSOC # 0012229 Report Period Beginning: 01/01/00

Ending: 12/31/00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 5,455,729	1
2	Discounts and Allowances for all Levels	(404,320)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,051,409	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	230,976	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 230,976	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	3,407	12
13	Barber and Beauty Care	20,574	13
14	Non-Patient Meals	17,759	14
15	Telephone, Television and Radic		15
16	Rental of Facility Space		16
17	Sale of Drugs	29,685	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	58,932	21
22	Laundry	369	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 130,726	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	(153,962)	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ (153,962)	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See supplemental schedule</u>	187,220	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 187,220	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,446,369	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,406,077	31
32	Health Care	2,503,254	32
33	General Administration	1,298,221	33
	B. Capital Expense		
34	Ownership	668,090	34
	C. Ancillary Expense		
35	Special Cost Centers	183,256	35
36	Provider Participation Fee	66,978	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,125,876	40
41	Income before Income Taxes (line 30 minus line 40)**	(679,507)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (679,507)	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? Non Profit If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

DESCRIPTION	AMOUNT
1 Vending Commissions	1,063
2 Income A T & T Wireless	8,482
3 Apartment Application Fees	200
4 Resident Fees - Apartments	102,923
5 Amortization of Deferred Entrance Fees	57,495
6 Income Dietary Supply	17,057
7	
8	
9	
10	
11	
12	
13	
14	
15	
16	
17	
18	
19	
20	
TOTALS	187,220

Facility Name & ID Number **NORWEGIAN LUTHERAN BETHESDA ASSOCIATION**# **0012229**Report Period Beginning: **01/01/00**

Ending:

12/31/00**XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)**

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,029	2,213	\$ 77,762	\$ 35.14	1
2	Assistant Director of Nursing	2,649	2,961	66,129	22.33	2
3	Registered Nurses	21,378	23,541	469,512	19.94	3
4	Licensed Practical Nurses	20,324	21,702	353,612	16.29	4
5	Nurse Aides & Orderlies	87,773	95,123	964,414	10.14	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,849	2,184	35,125	16.08	9
10	Activity Assistants	9,260	10,164	91,471	9.00	10
11	Social Service Workers	1,861	2,092	35,007	16.73	11
12	Dietician					12
13	Food Service Supervisor	916	1,204	22,152	18.40	13
14	Head Cook	3,554	3,723	43,302	11.63	14
15	Cook Helpers/Assistants	24,008	26,394	217,765	8.25	15
16	Dishwashers	6,577	7,235	66,586	9.20	16
17	Maintenance Workers	5,923	6,612	109,185	16.51	17
18	Housekeepers	19,406	21,664	198,679	9.17	18
19	Laundry	5,447	5,970	44,993	7.54	19
20	Administrator	1,956	2,333	118,010	50.58	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	12,112	13,365	229,308	17.16	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,916	2,072	23,612	11.40	31
32	Other Health Care(specify)					32
33	Other(specify)	1,388	1,496	25,201	16.85	33
34	TOTAL (lines 1 - 33)	230,326	252,048	\$ 3,191,825 *	\$ 12.66	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	103	\$ 4,824	1-3	35
36	Medical Director	240	10,800	9-3	36
37	Medical Records Consultant	20	1,000	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Mthly	900	10-3	39
40	Physical Therapy Consultant		1,362	10A-3	40
41	Occupational Therapy Consultant	2	113	10A-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47	Chaplain's Stipend	Mthly	11,400	12-3	47
48	Food Management		55,852	1-3	48
49	TOTAL (lines 35 - 48)	365	\$ 86,251		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	980	\$ 40,642	10-3	50
51	Licensed Practical Nurses	2,856	99,602	10-3	51
52	Nurse Aides	3,692	71,373	10-3	52
53	TOTAL (lines 50 - 52)	7,528	\$ 211,617		53

1,388	1,496	\$ 25,201	\$ 16.85
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A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description		Amount	Description	Amount
Carol Page Beecher	Administrator	0	\$ 118,010	Workers' Compensation Insurance	\$	79,239	IDPH License Fee	\$ 200
				Unemployment Compensation Insurance		4,798	Advertising: Employee Recruitment	50,935
				FICA Taxes		242,992	Health Care Worker Background Check	
				Employee Health Insurance		137,698	(Indicate # of checks performed <u>67</u>)	804
				Employee Meals		10,376	Licenses and Fees	933
				Illinois Municipal Retirement Fund (IMRF)*			Dues & Subscriptions	7,156
				Employer 403B Contributions		30,190	Yellow Page Advertising	12,269
				Employee Benefits		13,481	Public Relations	861
							Advertising and Fund Raising	11,523
							Joint Commission	2,131
							Less: Public Relations Expense	(861)
							Non-allowable advertising	(11,523)
							Yellow page advertising	(12,269)
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)							TOTAL (agree to Sch. V, line 20, col. 8)	
			\$ 118,010			\$ 518,774		\$ 62,159
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
			\$			\$	Out-of-State Travel	\$
							In-State Travel	
							Seminar Expense	4,767
							Entertainment Expense	()
							(agree to Sch. V, line 24, col. 8)	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)				TOTAL			TOTAL	
			\$			\$		\$ 4,767
C. Professional Services								
Vendor/Payee	Type		Amount					
Sentry Surveillance	Security		\$ 522					
CIT Technology	Security		261					
Securitylink from Ameritech	Security		829					
ADP	Payroll Processing		14,637					
Life Services Network	Strategic Planning		250					
Frost, Ruttenberg & Rothblatt	Accounting, Audit, Computer		26,692					
RH Positive	Computer Support		2,538					
Accu-Med Services	Computer Support		900					
Medical Communications Software	Computer Support		1,590					
See Attached			144,615					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)								
			\$ 192,834					

* Attach copy of IMRF notifications

**See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

[illegible]

Facility Name & ID Number NORWEGIAN LUTHERAN BETHESDA ASSOCIATION

0012229

Report Period Beginning: 01/01/00

Ending: 12/31/00

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. Life Services Network \$6,046
- (3) Did the nursing home make political contributions or payments to a political organization? No If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 62,502 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over _____
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 66,978
This amount is to be recorded on line 42 of Schedule V
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions
- (15) Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V. \$ 10,376 Has any meal income been offset against related costs? Yes, 2-7 Indicate the amount. \$ 17,759
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? None
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Frost, Ruttenberg & Rothblatt The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? Yes If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.

Date: 07/17/2000

To: Administrator/Cost Report Preparer

From: Office of Health Finance

Re: 2000 Long Term Care Cost Report and Instructions on Diskette
Information Regarding the Lotus 5.0 and Excel 97 Versions of the Cost Report

Enclosed you will find a copy of the 2000 cost report and instructions on diskette. For 1999, the majority of nursing homes used the diskette to prepare their cost report. We would appreciate it if you could complete your 2000 cost report using this diskette.

If you choose not to use the diskette, you may print the 2000 cost report form and manually complete the report. If you do not have the ability to print the cost report form and instructions, please contact our office at 217/782-1630 to request a paper copy to be mailed to you.

As is stated on page 1 of the cost report instructions, this report should cover the facility's fiscal year ending in 2000. It is due on September 30, 2000, or ninety days after the close of the facility's fiscal year, **whichever comes later**. Please refer to the instructions for the remainder of the filing requirements.

There are two 2000 cost report files on the disk you have received. One file has been created for use with Lotus 5.0 for Windows. The other file has been created for use with Excel 97. A copy of the 2000 cost report instructions has been included on the diskette also. The name of the file is Instr00. It has been created for use with Word Perfect 6.1. Please use this 2000 diskette. **Printed copies of the report from the 1999 cost report diskette or earlier diskettes will NOT be accepted.**

Each page is on a separate worksheet. The file has been sealed. The cells where data is to be entered have been unprotected. Do not change the cost report form. We must have every form the same. Any changes made to the cost report form will cause us to consider the filed cost report incomplete until the form is correctly filed. Complete page one first. The facility name, IDPH ID# and the report period dates have been linked to each page. (Be sure to enter the IDPH licensed name of the facility.) **When entering data on pages 3 and 4, do not include decimals. Please round to whole numbers. When entering the years on page 12 do not enter various or other text in columns 2 or 3.**

Print macros have been written that will print each individual page or the entire report.

WARNING: Do NOT use drag & drop, cut or move commands. These commands may ruin the file and/or formulas. Then you will have to close the file and start from the last time you saved it.

As you know, save your work frequently to prevent losses of large amounts of information.

The cost report must be printed on 8 ½ by 14 size white paper with an 8 ½ by 14 image on the paper. To ensure an 8 ½ by 14 size image, check the paper size in the Printer Setup. When printing the cost report, be sure the "Selected Range" is checked. If "Current Worksheet" or "All Worksheets" are selected, the printed report will be smaller than it should be. These three selections appear in the Print dialog box. **Please do not reduce the image to 8 ½ by 11. We cannot accept a report with an 8 ½ by 11 image.** After printing the cost report, please review the copy for accuracy and completeness before mailing it to The Office of Health Finance. **Please send in the completed diskette with your paper copy, (being sure to make a copy of the diskette for your records).** Also, please make sure both the completed diskette and the paper copy agree prior to sending to our office.

Notes Applicable only to Lotus users

The entire cost report is in one file named Report00.wk4. A print preview button has been added to the bottom of each page. You may want to preview each page to ensure there are no problems before you print the entire cost report. To preview a page, click this button, then click File-Preview as normal. Also, macros have been written that will allow you to change the column width or row height of a cell or range of cells. **Only use these commands on the extra pages (24 through 33).** The print menu or the other macros menu will appear on the menu bar after you click the macro button. A macro that allows you to "Freeze Both Titles" has been added also. This will be helpful for data entry. **When saving the file in Lotus, please save it as a "WK4" file type instead of a "123" file type. To do this, click File-Save As, and then ensure the file type is "WK4".**

To copy worksheets that you have created into the blank pages at the end of the report, use File-Combine. This will bring in the styles you used in your worksheet (except for the column width and the row height). This does not work if you are using Lotus 97. Extra sheets for pages 6, 8 and 12 have been included in the file. Click the macro buttons on these pages to make them available.

Notes Applicable only to Excel users

The entire cost report is in one file named Report00.xls. In an Excel 97 file that has been sealed, you can press the Tab key to go to the next unprotected cell. By pressing Shift-Tab, you can go to the previous unprotected cell. Extra sheets for pages 6, 8 and 12 have been included in the file. Click Format-Sheet-Unhide to see the sheets available. Also there are some blank unprotected sheets after "Page 23".

If you have any questions concerning the diskette, please call Randy Hulskotter at (217) 782-1630.

RH/rw